MDFORLIVES IN-DEPTH INSIGHT REPORT

Women's Cardiovascular Care: Where Standard Pathways Still Need a Sex-Specific Lens

A peer insight report on female-specific risk enhancers, INOCA and microvascular disease, diagnostic bias, access to advanced testing, treatment intensity, cardio-obstetric integration and evidence confidence.

Cardiologists · 6 countries · Global peer perspectives

52	77	6	67.5%
Complete responses	Survey records	Countries represented	Completion rate

THE CLINICAL QUESTION

Where do standard cardiovascular pathways still fail to capture the clinical reality of women?

The survey shows a mixed picture. Many cardiologists actively account for female-specific risk and pursue microvascular evaluation, yet they still report recurring diagnostic misattribution, payer friction, treatment hesitancy and fragmented cardio-obstetric pathways.

The full report tracks the disconnect between clinical awareness, diagnostic access, treatment intensity, women-specific evidence and system integration.

Coverage: United States, United Kingdom, Canada, Italy, France, Germany. Survey ID: 8917223. Percentages are shown exactly as reported at each question base.

EXECUTIVE SUMMARY

The pattern in one view

The survey does not show a cardiology workforce unaware of women's cardiovascular disease. It shows a workforce trying to apply a more sex-specific clinical model inside systems that remain partly generic. Recognition of reproductive risk, INOCA and SCAD is increasingly visible, yet payer rules, treatment behavior, trial representation and referral infrastructure still create friction. The next step is therefore implementation: making women-specific risk and pathways routine enough that they no longer depend on an individual clinician remembering to compensate for the system.

01 / RISK HISTORY
54.7%
systematically screen female-specific risk enhancers and may escalate testing. Reproductive and obstetric history is being used actively by a majority, but not universally.

02 / INOCA
66.0%
pursue advanced physiology after a non-obstructive angiogram or CCTA. Most respondents do not interpret a "clear" epicardial angiogram as the end of the cardiac workup.

03 / TRIAGE BIAS
92.3%
still see female ischemia initially attributed to anxiety or panic at least occasionally. The pattern remains visible even in the era of standardized emergency pathways.

04 / ACCESS
94.3%
face moderate or severe prior-authorization friction for advanced microvascular testing. Diagnostic intent can be strong while access to PET, MRI or functional testing remains constrained.

Reading across the findings: The survey shows a mixed picture. Many cardiologists actively account for female-specific risk and pursue microvascular evaluation, yet they still report recurring diagnostic misattribution, payer friction, treatment hesitancy and fragmented cardio-obstetric pathways.

SECTION 01

Female-specific risk enhancers are being used, but not yet as a universal default

CONTEXT
Female-specific risk enhancers are being used, but not yet as a universal default is one part of the wider operating pattern captured in this survey.

DATA
54.7% systematically screen reproductive and obstetric risk enhancers and may escalate low-to-intermediate risk patients to calcium scoring or CCTA. 28.3% use these factors selectively, while 17.0% rarely do because standard EHR risk engines remain the primary driver.

INSIGHT
The majority report an active sex-specific risk lens, but the workflow still depends partly on clinician memory and selective history-taking rather than a universally embedded digital pathway.

WHY IT MATTERS
When risk factors are not structurally captured, consistency can vary by clinician, setting and how obviously the traditional score appears discordant.

Use of female-specific risk enhancers in long-term cardiovascular risk assessment
Percent of responding participants at this question

Systematically	54.7%
Selectively	28.3%
Rarely	17.0%

The majority report an active sex-specific risk lens, but the workflow still depends partly on clinician memory and selective history-taking rather than a universally embedded digital pathway.

When risk factors are not structurally captured, consistency can vary by clinician, setting and how obviously the traditional score appears discordant.

SECTION 02

A non-obstructive angiogram usually triggers more cardiac evaluation, not de-escalation

CONTEXT
A non-obstructive angiogram usually triggers more cardiac evaluation, not de-escalation is one part of the wider operating pattern captured in this survey.

DATA
66.0% pursue advanced physiology for coronary microvascular dysfunction, 28.3% initiate empiric cardioprotective or anti-anginal therapy without further advanced testing, and 5.7% de-escalate toward non-cardiac explanations.

INSIGHT
Most respondents recognize that non-obstructive epicardial disease does not exclude a clinically meaningful ischemic mechanism.

WHY IT MATTERS
INOCA pathways depend on access to specialized imaging or functional testing, making diagnostic recognition only the first step.

Next step after non-obstructive coronary findings in a symptomatic woman
Percent of responding participants at this question

Advanced physiology testing	66.0%
Empiric management	28.3%
De-escalation	5.7%

Most respondents recognize that non-obstructive epicardial disease does not exclude a clinically meaningful ischemic mechanism.

INOCA pathways depend on access to specialized imaging or functional testing, making diagnostic recognition only the first step.

SECTION 03

Diagnostic bias remains visible at the front door of acute care

CONTEXT
Diagnostic bias remains visible at the front door of acute care is one part of the wider operating pattern captured in this survey.

DATA
40.4% say they constantly observe female acute ischemia initially misattributed to anxiety or panic, 51.9% see it occasionally, and 7.7% rarely observe it.

INSIGHT
The most striking finding is not that bias exists in isolated cases. It is that more than nine in ten respondents still see it at least occasionally.

WHY IT MATTERS
Early symptom framing influences testing, triage intensity and time to definitive treatment, especially in presentations that do not fit the classic chest-pain narrative.

How often female acute ischemia is initially attributed to anxiety or panic
Percent of responding participants at this question

Constantly	40.4%
Occasionally	51.9%
Rarely	7.7%

The most striking finding is not that bias exists in isolated cases. It is that more than nine in ten respondents still see it at least occasionally.

Early symptom framing influences testing, triage intensity and time to definitive treatment, especially in presentations that do not fit the classic chest-pain narrative.

SECTION 04

Advanced diagnostic intent collides with payer friction

CONTEXT
Advanced diagnostic intent collides with payer friction is one part of the wider operating pattern captured in this survey.

DATA
46.2% describe prior authorization for advanced microvascular imaging as severe, 48.1% as moderate, and only 5.8% as low.

INSIGHT
The survey shows a near-universal access burden exactly where the diagnostic pathway becomes more specialized.

WHY IT MATTERS
A clinician can recognize INOCA and still be unable to confirm the mechanism promptly if PET, perfusion MRI or functional testing requires prolonged appeals or coding work.

Prior-authorization friction for advanced microvascular imaging
Percent of responding participants at this question

Severe	46.2%
Moderate	48.1%
Low	5.8%

The survey shows a near-universal access burden exactly where the diagnostic pathway becomes more specialized.

A clinician can recognize INOCA and still be unable to confirm the mechanism promptly if PET, perfusion MRI or functional testing requires prolonged appeals or coding work.

SECTION 05

Treatment intensity and confidence are shaped by both behavior and evidence

CONTEXT
Treatment intensity and confidence are shaped by both behavior and evidence is one part of the wider operating pattern captured in this survey.

DATA
59.6% identify provider hesitancy as the primary driver of lower GDMT titration in women, compared with 30.8% who emphasize biological intolerance and 9.6% who point to follow-up fractures. Separately, 40.4% say underrepresentation of women in major trials creates high impact on confidence when applying guideline recommendations.

INSIGHT
The responses locate the care gap in two places at once: clinician behavior and the evidence base that informs that behavior.

WHY IT MATTERS
Closing an outcomes gap requires both stronger representation and consistent application of proven therapy, rather than assuming one problem can substitute for the other.

Perceived primary driver of lower medication titration in female patients
Percent of responding participants at this question

Provider hesitancy	59.6%
Biological intolerance	30.8%
Follow-up fractures	9.6%

The responses locate the care gap in two places at once: clinician behavior and the evidence base that informs that behavior.

Closing an outcomes gap requires both stronger representation and consistent application of proven therapy, rather than assuming one problem can substitute for the other.

SECTION 06

The pregnancy-to-cardiology bridge is still more reactive than integrated

CONTEXT
The pregnancy-to-cardiology bridge is still more reactive than integrated is one part of the wider operating pattern captured in this survey.

DATA
28.8% report seamless protocol-driven cardio-obstetric teams, 63.5% describe segmented referrals that occur reactively after decompensation, and 7.7% report no structured bridge.

INSIGHT
The dominant model connects specialties after risk becomes clinically obvious rather than building automatic co-management around known high-risk states.

WHY IT MATTERS
Pregnancy-related cardiovascular risk is longitudinal. A fragmented handoff can lose the opportunity to translate obstetric history into future cardiovascular prevention and monitoring.

Integration between OB/GYN and Cardiology for high-risk pregnancy
Percent of responding participants at this question

Seamlessly integrated	28.8%
Segmented and reactive	63.5%
Completely disconnected	7.7%

The dominant model connects specialties after risk becomes clinically obvious rather than building automatic co-management around known high-risk states.

Pregnancy-related cardiovascular risk is longitudinal. A fragmented handoff can lose the opportunity to translate obstetric history into future cardiovascular prevention and monitoring.

OPEN-ENDED PEER INSIGHT

What clinicians said when the answer choices disappeared

Question: What is the single most critical change Cardiology must make, whether in diagnostic tech, electronic medical records, or clinical trials, to finally close the outcomes gap for women with cardiovascular disease?

Make sex-specific pathways the default
Several responses called for sex-specific diagnostic and treatment pathways, guideline thresholds or risk scores embedded directly into clinical workflows and EHRs.

Improve representation in trials
Multiple cardiologists asked for greater or one-to-one female representation in clinical studies so efficacy, safety and thresholds are not inferred from predominantly male cohorts.

Understand physiology and thresholds better
Respondents raised the need to clarify whether normal ranges, disease mechanisms and treatment thresholds should differ by sex.

Cultural recognition and earlier detection
Some responses emphasized recognizing cardiovascular disease in women with the same seriousness as in men, changing clinical culture and improving early detection.

There is not complete consensus
A minority said no single change was needed, no change was necessary, or the identified gaps were too multiple to reduce to one intervention.

"Make sex-specific diagnosis and treatment pathways the default at every stage of cardiovascular care, embedded directly into EHRs and clinical workflows."

Interpretation note: These themes are qualitative and directional, based on substantive responses in the open-ended export. They are not weighted percentages.

PRACTICE PATTERN

What may be sitting underneath the responses

These are interpretive patterns, not clinical recommendations. They describe tensions that appear when the survey findings are read together.

01 / WORKFLOW
Clinical intent is only one part of delivery
The survey repeatedly shows that timing, access, coordination and administrative design shape whether a clinical decision can be carried through.

02 / EVIDENCE
Confidence depends on the evidence available at the moment of decision
Where evidence is incomplete, difficult to access or not well translated into workflow, clinicians create compensating behaviors such as escalation, workarounds or selective use.

03 / SYSTEMS
Specialty expertise cannot fully offset system friction
Many barriers sit outside the clinician's direct control, which means the next improvement often requires redesign around the specialist rather than more specialist effort.

CLOSING PERSPECTIVE

Women's Cardiovascular Care: Where Standard Pathways Still Need a Sex-Specific Lens

The survey does not show a cardiology workforce unaware of women's cardiovascular disease. It shows a workforce trying to apply a more sex-specific clinical model inside systems that remain partly generic. Recognition of reproductive risk, INOCA and SCAD is increasingly visible, yet payer rules, treatment behavior, trial representation and referral infrastructure still create friction. The next step is therefore implementation: making women-specific risk and pathways routine enough that they no longer depend on an individual clinician remembering to compensate for the system.

CONCEPT FAQ

Clinical questions about women's cardiovascular risk, INOCA, SCAD and cardio-obstetrics

Why does pregnancy history matter in cardiovascular risk assessment?
Adverse pregnancy outcomes such as hypertensive disorders of pregnancy, gestational diabetes, preterm delivery and some other pregnancy complications are associated with a higher likelihood of later cardiovascular risk factors and cardiovascular disease. Pregnancy history can therefore add clinically relevant context to long-term risk assessment.

What is INOCA?
INOCA means ischemia with non-obstructive coronary arteries. A patient can have ischemic symptoms even when angiography does not show a major obstructive stenosis. Coronary microvascular dysfunction and vasomotor disorders are important mechanisms, and coronary microvascular disease is more common in women.

What is spontaneous coronary artery dissection (SCAD)?
SCAD is a spontaneous tear or separation within the wall of a coronary artery that can reduce blood flow and cause acute coronary syndrome or myocardial infarction. It occurs predominantly in women and often affects people without the usual profile of atherosclerotic coronary disease.

Why can SCAD require a different management approach from a typical plaque-rupture heart attack?
The underlying problem is an arterial wall dissection rather than a conventional atherosclerotic blockage. Many stable SCAD lesions can heal with conservative management, while intervention may be needed in selected high-risk situations such as ongoing ischemia or hemodynamic instability.

What is cardio-obstetrics?
Cardio-obstetrics is a multidisciplinary approach to cardiovascular care before, during and after pregnancy. It brings together cardiology, obstetrics or maternal-fetal medicine and other relevant specialties to assess risk, coordinate treatment and plan follow-up for patients with cardiovascular disease or elevated pregnancy-related risk.

Do women always have different heart-attack symptoms from men?
No. Chest pain or discomfort remains the most common heart-attack symptom in women as well as men. Women may also have shortness of breath, nausea, unusual fatigue, or pain in the back, jaw, neck or arm. Under-recognition of these presentations can contribute to delayed evaluation.

Clinical context sources: American Heart Association: Coronary Microvascular Disease · American Heart Association: Spontaneous Coronary Artery Dissection · AHA: Adverse Pregnancy Outcomes and Cardiovascular Disease Risk · AHA: Cardiovascular Considerations in Pregnancy. These FAQs provide general educational context and do not replace specialty guidance or patient-specific clinical judgment.

SELECTED EXTERNAL CONTEXT

- American Heart Association, Preeclampsia, High Blood Pressure and Maternal Health, March 2026
- American Heart Association, Coronary Microvascular Disease
- American Heart Association, INOCA Is a Women's Health Crisis Hiding in Plain Sight

Source note: External references provide clinical and regulatory context. All survey percentages and response counts come from the MDForLives survey export identified above.

MDForLives
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Real Opinions to Insights. Validated by Data.

Visual Graphs and Backend Data

Percentages and counts are reproduced from MDForLives survey SGID 8917223. Question bases vary across partial completes.

Survey profile

Metric	Value
Completion rate	67.5%
Complete	52
Partial	25
Total survey records	77
Countries	United States, United Kingdom, Canada, Italy, France, Germany

Section 01: Use of female-specific risk enhancers in long-term cardiovascular risk assessment

Response option	Percent	Responses
Systematically	54.7%	29
Selectively	28.3%	15
Rarely	17.0%	9

Section 02: Next step after non-obstructive coronary findings in a symptomatic woman

Response option	Percent	Responses
Advanced physiology testing	66.0%	35
Empiric management	28.3%	15
De-escalation	5.7%	3

Section 03: How often female acute ischemia is initially attributed to anxiety or panic

Response option	Percent	Responses
Constantly	40.4%	21
Occasionally	51.9%	27
Rarely	7.7%	4

Section 04: Prior-authorization friction for advanced microvascular imaging

Response option	Percent	Responses
Severe	46.2%	24
Moderate	48.1%	25
Low	5.8%	3

Section 05: Perceived primary driver of lower medication titration in female patients

Response option	Percent	Responses
Provider hesitancy	59.6%	31
Biological intolerance	30.8%	16
Follow-up fractures	9.6%	5

Section 06: Integration between OB/GYN and Cardiology for high-risk pregnancy

Response option	Percent	Responses
Seamlessly integrated	28.8%	15
Segmented and reactive	63.5%	33
Completely disconnected	7.7%	4